Commentary

Can the Specialist Be a Generalist?

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There currently is a perceived or real shortage of practicing generalist physicians in the United States. One suggested remedy is to retrain specialists to gain primary care competence.[1-5] This solution begs a very big question: Can a specialist be a generalist? If the question is posed in this manner, the answer must be "Yes, but not easily." Can a professional football player be a ballet star? Can a rabbi be a priest? Yes, but not easily and perhaps not advisably. A more germane question is "Will a specialist choose to be a generalist?" or "Should a specialist be a generalist?"

In part, the answer depends on some specifics. Are we proposing a national mandate or policy, or are we asking if this can be done in certain circumstances? Also, all specialists are not the same. Are we referring to community-based rheumatologists who spend most of their time doing primary care, or are we focusing on academic cardiovascular surgeons who have less to do because of the success of primary care physicians in reducing the prevalence of coronary heart disease?

This raises an important point: Specialists will not change their practice to primary care until the suspected or actual threat of income loss becomes such that they feel there is little choice left.[3]

Definitions

Before taking a position on whether specialists will become generalists, let us define some terms.[6,7]

Primary care includes family physicians, general internists, and general pediatricians. These physicians

> are specifically trained to provide first contact, coordinated, comprehensive, and continuous care to persons with a broad range of health concerns not limited by problem origin, gender, organ system or diagnosis. Primary care includes the management of acute and chronic illness, preventive services, counseling and prevention.[7(p261)]

Subspecialists—medical or surgical—are not trained in these generalist disciplines. The scope of their practice is "in some way limited to or focused on a particular disease process, condition or organ system or on the use of specific technological interventions."[7(p261)]

Background

Currently, only a third of allopathic physicians in the United States are practicing generalists. Just 30 years ago this figure was 50%, and 60 years ago it was 90%.

More troublesome is the fact that in 1982, more than a third of our medical school graduates went into primary care fields—14% in general medicine and 15% in family practice, with the remainder in pediatrics—whereas in 1993 only 15% said they plan to enter a primary care field—3% in general medicine, 3% in pediatrics, and 9% in family practice.[9] Why is this? In 1993 the Association of American Medical Colleges appointed a Task Force on the Generalist. This group administered a questionnaire to a large number of graduating medical students to find out the reasons for certain career choices. Let us look at their findings.[10]

- *Practice demographics.* In general medicine, patients seek care with undifferentiated problems. They are often elderly and frequently have chronic illness or psychosocial problems, or both. Recently an increasing number of patients have problems related to the human immunodeficiency virus. Many patients have relatively straightforward, self-limited, even mundane illnesses.[3] Primary care physicians value continuity of care and are interested in psychosocial issues. They are reasonably comfortable making decisions based on vague probabilities. Those attracted to specialty fields desire tangible and immediate results and prefer more certainty in their therapeutic decision making.
- *Intellectual content of the field.* Generalists must be comfortable with a large, ever-changing body of knowledge. This is often intimidating to the specialty-bound students and residents who prefer a limited information base that they can master comfortably.[11]
- *Lifestyle.* Because specialists are able to make more money in a shorter period of time, those entering fields with controllable lifestyles—anesthesia, radiology, dermatology, emergency medicine, and many of the surgical subspecialties—often work a third to half the number of hours per week that a primary care physician does, and in so doing make a substantially higher income.[10,11]
- *Debt burden and finances.*[11-15] The average debt of today's graduating medical student is $46,000. It is $75,000 if the student graduates from a private medical school. To comfortably repay a debt of $75,000 within five years requires an annual income of $145,000. If the debt is $120,000 (which is becoming more frequent), the

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physician would need an annual income of $266,000 to repay this amount within the same time period.

The median income of a general internist is about $112,000; of a gastroenterologist, $186,000; of a radiologist and anesthesiologist, $300,000; and of a cardiovascular surgeon it is $441,000. For every 1% increase in anticipated income, the number of students choosing that specialty increases by 0.5%.[15] If a specialist has been in practice several years, expenses or debt burden will be in equilibrium with income, and it would be painful indeed to adjust to today's primary care physician's salary.

- *Personality factors and prestige.*[10-12] This is a common reason given for a specific career choice: a specialty is chosen that is thought to be appropriate to a student's temperament and personality. This reflects, in a complex way, a mixture of aversions and attractions to the actual and apparent attributes of the various specialties. Here the perception of the prestige of the field plays an important role and is determined both by patient attitudes and those of the faculty who taught the student.

Practical Considerations

Assuming that there are specialists who really do wish to (or have to) retool to be primary care physicians, who will pay for the retraining, define the core competence, and issue credentials for the training programs and the trainees?[7] No guidelines exist for retraining specialists to become generalists, and this becomes even more complicated given the wide variety of specialty types. Resolving these issues is important because in the reformed health care system, reimbursement for primary care will be linked to demonstrable or certifiable competence in this area.

There are four possible ways to do this[7]:

- *Formal board certification.* A specialist would reenter an existing primary care training program, in all likelihood with a year's credit given for the advanced training that specialists have already had in their field. This would be a costly option, both in time and money.
- *An organizational certificate of qualification.* Specialists could use functioning primary care residency programs for their clinical practice and supervision, but in a less intense way than in the first option. A graduate of this program would then be certified by an existing organization such as the American Council of Graduate Medical Education. Again, this would require a major investment of time and money.
- *An institutional certificate of completion.* A specific institution may choose to retrain its own specialists and issue a site-specific certificate of completion. This likely would be the continuing medical education model most attractive to practicing subspecialists desiring a career change. The problems here have to do with a lack of standard curricula and an unclear meaning of a certificate of completion outside the sponsoring institution.
- *Primary care apprenticeship.* A subspecialist would simply shadow a certified generalist until both thought that the specialist was competent to function alone. Variability of experience and lack of quality control are clear drawbacks to this option.

The Answer

Professionals are determined by their knowledge, skills, attitudes, and behaviors. Any specialist could readily learn the knowledge and skills of a generalist, but retraining would definitely be necessary. But what about the attitudes and behaviors that determine satisfaction of both physicians and patients and effectiveness? Would specialists enjoy seeing the types of patients generalists see, and would they be sufficiently motivated to remain current and skilled in this field? Would they tolerate the necessary continuous availability to their patients? Would they practice the necessary cost-effective care required in a managed care system? Data exist that suggest that specialists' care for the same type of patient is more expensive than that of generalists.[16]

I think that attitudes that determine the original decision to enter the specialist's chosen field are deep-seated—not immutable, but close to it. So for me, the answer to whether specialists can become generalists is this: Except under special circumstances, the priest and the rabbi should stick to their chosen religions; the football player and ballet star should remain on the field and the stage, respectively; and the specialist and generalist should continue to do what they love and do the best.

Postscript

In all likelihood, special circumstances will prevail. The relentless growth of managed care will continue; more care will be provided by generalists in partnership with physician-extenders; and the subspecialist, both community and university-based, will be faced with a dwindling source of patients. What advice is there for these committed and hard-working physicians? Certifying competency eventually will be required. Until then, I suggest the following, especially applicable to subspecialists who have limited their practices to a narrow field:

- Change is always difficult, abrupt change more so than gradual. Anticipate this and make the necessary practice transitions sooner rather than later. If given a choice, sign on with managed care organizations as a primary care physician rather than as a subspecialist;
- Trepidation about the unfamiliar is natural. Broadening exposure to primary care problems will lead to increased comfort (enjoyment?) with this discipline;
- We avoid that which makes us feel inadequate. Learn about dizziness, headaches, back pain, functional bowel disorders, and the like. Having this framework when seeing patients with mundane, self-limited, and stress-related problems promotes confidence, and from this sense of competence professional satisfaction will likely follow;
- Try to consciously change the goal of encounters with patients from a need for a definitive diagnosis and treatment to an understanding of the human condition and the value of the therapeutic relationship. This is the

underpinning of the effectiveness of a generalist and may be the most difficult adjustment to make;

- Associate with those generalist colleagues who relish the excitement of general internal medicine, who thoroughly enjoy the daily challenges of solving the myriad of undifferentiated medical problems that they see. Attend their conferences. Freely and frequently discuss patients with them; and
- Do not neglect that which sustained you intellectually and professionally for many years. Continue to provide consultations in your area of expertise. Attend subspecialty conferences and, time permitting, teach on university consultation services and in the clinics.

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